

4.19 Payments for Medical and Remedial Care and Services

Methods and Standards for Determining Payment Rates for Intermediate Care Facilities for the Mentally Retarded

I. Cost Finding and Reporting

All Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The mandated chart of Accounts for ICF/MRs must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for ICF/MRs must be reported on the Financial and Statistical Report for ICF/MRs. The reports must be completed in accordance with generally accepted accounting principles and the accrual method of accounting and must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating ICF/MR facility costs are to be reported semi-annually. The semi-annual reporting periods are January 1st through June 30th and July 1st through December 31st. After December 31, 2001 facility cost will be reported on an annual basis. The annual reporting period will be July 1st through June 30th.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked **within sixty (60) days** following the end of the reporting period.

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An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances, where requested and justified by the facility in writing, before the closing date. Requests for an extension of the filing period are to be addressed in writing to:

Director, Financial Analysis & Rate Setting Division
Bureau for Medical Services
Department of Health and Human Resources
350 Capital Street, Room 251
Charleston, West Virginia 25301-3706

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the 60 day filing period where no extension has been granted to the facility, or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed for each day that the cost report is delinquent, and will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subjected to these penalty provisions. Facilities submitting cost reports after the beginning of the rate period (defined later) will receive a rate effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected. The corrected cost report data must be received within thirty (30) days after original rate notification in order to be accepted. However changes to peer group (defined later) reimbursement rates will only be adjusted if there are pervasive multiple facility errors in the cost data submitted. The Department will make revisions resultant from computational errors in the rate determination process at any time, including at the completion of an audit review.

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G. New Facilities - Projected Rates

A projected rate will be established for new ICF/MR facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. The projected rate will be the base reimbursement rates established for the peer group in which the new facility falls, adjusted for ICAP acuity consideration and capital cost. Each such facility on a projected rate must submit the mandated cost report during the projected rate period.

H. Change of Ownership - Projected Rates

A projected rate will be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility. However, the only portion of the old operating entity's rate that will be changed from the facilities current peer group would be the capital reimbursement portion.

Where there has been a change of ownership, the old operating entity must submit a closing cost report due 60 days after the effective date of ownership change. The new operating entity must submit the mandated cost report beginning with the date new ownership occurred and ending with the normal cost reporting cycle.

I. Change in Bed Size

Any ICF/MR facility changing bed size will receive a new reimbursement rate based on the facilities new peer group base rate, adjusted for ICAP acuity and capital cost. The facility must submit a closing cost report 60 days after the effective date of the bed change. The facility must then submit a new cost report beginning with the date the bed change occurred ending with the normal cost reporting cycle.

J. Maintenance of Records

Financial and statistical records must be maintained by the facility to support and verify the information submitted on cost reports. Such records must be maintained for a minimum of five (5) years from the date of the report, and will be furnished upon request to the Department or Federal officials.

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The State agency will maintain cost reports for a minimum of five (5) years from date of receipt.

II. Allowable Costs / Rate Determination

Reimbursement for ICF/MR services is limited to those costs required to provide active treatment to people with mental retardation and related conditions. These are facility operating costs, client direct service costs, and costs for the physical setting.

Reported allowable costs are grouped into one of the following cost centers utilizing the Medicaid Chart of Accounts - ICF/MR cost centers are Direct Care/Nursing Staff, Medical and Other, Day Programming/Supportive Employment, Room and Board and Administration. A cost upper limit is developed in the aggregate by peer group for each cost center service, which becomes the maximum allowable base cost for reimbursement purposes. There are three facility peer groups: 1-7 beds, 8 beds, and 8+ beds. Allowable costs are determined by the following methodologies:

1. Cost Centers

- A. Direct Care/Nursing Staff - Direct Care/Nursing Staff reimbursement areas are direct care staff, staff supervisor, RN, LPN, QMRP, and a benefits and taxes adjustment.

The direct care staff, supervisor, RN, LPN and QMRP reimbursement is calculated by multiplying pre-determined staffing hours by standard wages rates. The pre-determined staffing hours are derived from various National and State historic staffing surveys. The staffing hours used for reimbursement purposes will be different based on the facility peer group and the acuity level of each client. There are four possible acuity levels of reimbursement for each peer group. The standard wage rates are based on the submitted cost reports. The State Agency may elect to update the wage rate standards based on periodic inflation factors or the most recently submitted cost reports. Each component is individually arrayed within their peer groups and a standard wage rate is calculated at an average percentile. Each facility within a peer group will be reimbursed at the peer group wage rate standard.

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The benefits and taxes percentage of the reimbursement rate will apply to all facilities regardless of peer group. All benefits and taxes (except administration and maintenance) for all providers will be combined and compared to all salaries (except administration and maintenance) for all providers, and an average percent benefits to salaries will be derived. The standard benefits percentage will come from the submitted cost reports. The State Agency may elect to update the percentage standard based on periodic inflation factors or the most recently submitted cost reports.

- B. Medical and Other - Medical and other costs are Activities, Nursing Supplies, Restorative, Medical Records, Transportation and Professional Services (excluding salaries and benefits, which are included in the Direct Care/Nursing Staff cost center). Cost standards for these services are computed from the current cost report submitted by the facilities. Each of the Medical and Other components costs are individually arrayed within their perspective peer groups and a cost standard per diem is calculated at an average percentile. Each of the individual peer group per diem cost standards are added together to arrive at the total Medical and Other cost standard. Each facility within a peer group will be reimbursed at the peer group cost standard.
- C. Day Programming/Supportive Employment - Cost standards are computed from the current cost report submitted by the facilities. Within each peer group, the costs of the facilities are arrayed and a cost standard per diem is calculated at an average percentile. Each facility within a peer group will be reimbursed at the peer group cost standard.
- D. Room and Board - Room and Board costs are Laundry and Housekeeping, Dietary and Utilities (excluding salaries and benefits, which are included in the Direct Care/Nursing Staff cost center). Cost standards for these services are computed from the current cost report submitted by the facilities. Each of the Room and Board component costs are individually arrayed within their perspective peer groups and a cost standard per diem is calculated at an average percentile.

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Each of the individual peer group per diem cost standards are added together to arrive at the total Room and Board cost standard. Each facility within a peer group will be reimbursed at the peer group cost standard.

- E. Administration - Administration is comprised of all administration and maintenance costs, including salaries and benefits (excluding provider tax). A cost standard for this service is computed from the current cost report submitted by the facilities. All facilities administration costs are arrayed, regardless of peer group, and a cost standard average percentage is calculated. Each facility will be reimbursed at the calculated cost standard percentage. The average percentage is then multiplied by total facility cost less provider tax and SAV capital, to arrive at the calculated administrative per diem reimbursement.

2. Cost of Capital

Reimbursement for cost capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). This value includes the necessary real property, and equipment associated with the actual use of the property as a long-term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified facilities by the Model Facility Standard, where appropriate. This valuation is the basis for capitalization to determine a per client day cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

A. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting therefrom the estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are Marshall Valuation Services and Boeckle Building Valuation Manual.

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B. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvements at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method that involves an analysis of loss in value from the following sources:

- (1) Physical deterioration; curable and incurable.
- (2) Functional obsolescence; curable and incurable.
- (3) Economic obsolescence.

The facility appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plan valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

C. Model Facility Standard

The Model Facility Standard is a composite of current regulations and criteria derived from several sources that include "Minimum Requirements of Construction and Equipment for Hospitals and Medical Facilities"- HHS Publication No. (HRS) 81-14500 and West Virginia Rules and Regulations for Licensing of Nursing Homes, where appropriate.

These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes that foster improved patient care or cost effective measures that do not compromise patient care.

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D. Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually prior to the October rate setting period. Updates may be performed at anytime during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate purposes.

A copy of the facility appraisal report is furnished to the facility for its records.

3. Provider Taxes

Provider tax expense stands alone for reimbursement purposes. A facility's actual provider tax is not used to determine any portion of the facility's reimbursement rate. An amount of 5.82% of the total of all facility costs, including capital, is used as the reimbursement for each facility's provider tax.

4. Compensation

Compensation, to be allowable, must be reasonable and determined to be for services that are necessary and related to patient care, and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked and compensation must be documented and reported to all appropriate State and Federal authorities for income tax, Social Security, and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the ICF/MR class. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per year worked in patient related duties.

Compensation must include the total benefit paid for the services rendered; i.e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

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5. Program Directors

Compensation for directors who do not work full time will be proportionate to the total number of hours worked. This includes persons who hold administrative positions in more than one facility, as well as those who hold various other positions in the same or alternate facility.

6. Owners

Administrators/owners will be compensated for administrative duties performed. Where the costs of administrative services are allowed, additional services performed by the administrator and/or owner are considered rendered primarily to protect their investment and are not allowable.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative functions required to operate the facility where the facility has a full-time administrator and/or assistant administrator or where other full-time or part-time staff positions are filled. Owner includes any individual or organization with an equity interest in the facility operation and any member of such individual's family including spouse's family. Owner also includes all partners and all stockholders in the facility operation and partners and stockholders of organizations that have an equity interest in the facility.

7. Non-Allowable Costs

Bad debt, charity, penalties and fines, and courtesy allowances are not included as allowable costs. Other items of expense may be specified in the State Agency regulations as non-allowable costs.

8. Purchases from Related Companies or Organizations

All related companies or organizations involved in any financial transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records that describe the nature and extent of such business transactions.

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Cost for purchases of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable service purchased elsewhere, whichever is less.

9. Rate Determination - ICF/MR

Individual facility client specific rates are established on a prospective basis, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, or reconciliation of audit findings related to falsification of data or overstatement of costs. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report for Behavioral Health Facilities and acuity level of residents.

The cost report is subject to desk review and then converted to cost per patient day. An inflation adjustment will be made to the rate for each rate period. The State will provide for periodic re-basing of rates based on the most recent cost report filings.

10. Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraised Value (SAV) methodology. Capital costs will be updated effective October 1st of each year.

a. Capitalization Rule

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land, building and equipment.

The Band of Investment approach is used to blend the allowable costs of mortgage money (fixed income capital) and the allowable cost of equity money (venture income capital) and the allowable cost of equity money (venture or equity capital) that produces a rate to reflect current money values in the mortgage market at the time of original indebtedness. This band of investment sets a 75:25 debt-service to equity ratio.

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The interest rate for the mortgage component is based on the Baa State and Local (Baa), plus 2 points (not to exceed 14%), current at the time of the facility's original indebtedness, modified by the use of the constant annual percent for nonprofit facilities.

The yield on equity allowance (for proprietary facilities) is based on the average United States Long-Term Composite Rate (USLT) current at the time of facility original indebtedness. The yield on appreciation is based on the average United States Long-Term Composite Rate (USLT) allowable during the cost reporting period.

b. Capital Allowance

For proprietary ICF/MR facilities the capital allowance per patient day is determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology, and by applying the appreciation factor to the accumulated appreciation as determined by the Standard Appraised Value (SAV) methodology. For non-profit facilities, the capital allowance is determined by applying the capitalization rate for the mortgage component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology.

11. Inflation Factor

After combining the various components, a factor is assigned to allowable costs (excluding capital costs) as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs are compared with the Consumer Price Index (CPI).

The amount of change experienced during the reporting period or the CPI becomes the inflation factor applied to the next rate setting period. The inflation factor, once set for a given rate period, may be adjusted periodically as it represents a reasonable expectation for cost increases.

Indicators used for tracing economic changes and trends include:

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1. Annual Cost Reporting

The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.

2. Regulatory Costs

Regulatory costs, such as minimum wage increase, FICA increase, and Worker's Compensation changes may be considered as a component of the inflation factor.

3. National Data

The Consumer Price Index (CPI) corresponding to the most current cost reporting period is analyzed and compared with state experience.

IV. Inventory for Client and Agency Planning (ICAP)

The Inventory for Client and Agency Planning (ICAP) is a comprehensive, structured instrument designed to assess the status, adaptive functioning, and service needs of clients. The ICAP provides the means to collect individual and aggregate information across a number of areas essential for evaluating clients and services. The ICAP records descriptive information, diagnostic status, functional limitations, adaptive behavior skills, problem behaviors, residential placement, habilitation and supportive services, and social, leisure, and daytime activities for individual clients. Its primary purpose is to aid in screening, monitoring, managing, planning, and evaluating services for handicapped, disabled, and elderly people.

ICAP information is recorded in a 16-page booklet that provides a record of diagnostic status, functional limitations, adaptive behavior, problem behavior, and service status and needs. A respondent who sees the client on a day-to-day basis completes an initial ICAP. The initial ICAP is followed by a quarterly ICAP. The quarterly ICAP is followed by an ICAP to be completed on the client's anniversary date. If there is a significant change in the client's condition a new ICAP may be warranted. If no significant changes are noted during a client's stay, an ICAP will only be completed on the client's anniversary date.

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Based on the ICAP score a client may fall into one of four (4) possible levels of care. The 4 reimbursement levels are Intermittent, Limited, Extensive, and Pervasive. With Intermittent being the lowest level of needed care for low intensity clients and Pervasive being the highest level of needed care for high intensity clients. For a client to fall into the Intermittent level of care an ICAP score of seventy (70) or greater is required. A client with Limited level of care needs requires an ICAP score between forty (40) and sixty-nine (69). A client with Extensive level of care needs requires an ICAP score between twenty (20) and thirty-nine (39). A client requiring Pervasive care needs will score between one (1) and nineteen (19) on the ICAP.

The ICAP score directly affects the reimbursement level of each client. The Direct Care portion of the reimbursement rate is adjusted to reflect the staffing levels needed to care for the ICAP level of the client. The higher the intensity needs of the client, the greater the reimbursement.

V. Administrative Review

Procedures to be followed for administrative review and evidentiary hearings related to the per diem rate established for facility reimbursement are found in Chapter 700, Long-Term Care Regulations.

VI. Audits

Department staff will perform a desk review of cost reports prior to rate setting, and will conduct on-site audits of facility records periodically.

A. Desk Review

Financial and statistical reports submitted by the participating facilities will be subjected to desk reviews and analysis for rate setting within 60 days of receipt. Incomplete and inaccurate cost reports are not accepted.

B. Field Audit

Periodic on-site audits of the financial and statistical record of each participating facility will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report, and all data to support payroll and census reports.

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These records must be maintained at the facility or be made available at the facility for review by Department staff for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled on-site review must be delivered to the Department within 15 days. Costs found to be unsubstantiated will be disallowed, and considered as an overpayment.

C. Record Retention

Audit reports will be maintained by the agency for five years following date of completion.

D. Credits and Adjustments

The State will account for and return the Federal portion of all overpayments to CMS (Center for Medicare and Medicaid Services of the Department of Health & Human Services) in accordance with the applicable Federal Laws and regulations.

VII. Leave of Absence Policy for ICF/MR

Reimbursement is generally limited to the actual days in the facility. However, payment may be authorized to reserve a certified bed when the ICF/MR resident is absent for temporary periods, for home visits or trial visits to other facilities and other therapeutic purposes. Payment for days of authorized absence shall be at the full rate of the facility's approved default per diem (not adjusted for acuity). A day of absence from the ICF/MR is defined as an absence when the resident spends a night away from the facility.

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A. Medical Leaves of Absence

Reimbursement will be paid for an ICF/MR resident who must be transferred to an inpatient hospital for care and treatment that can only be provided on an inpatient basis.

The maximum bed reservation for such authorized medical absences shall be limited to 14 consecutive days, provided the resident is scheduled to return to the ICF/MR facility following discharge from the hospital. If the bed is used during the client's absence for emergency or respite care, it will in no way jeopardize or delay the return of the hospitalized resident to the facility. However, such short-term use of the bed is not acceptable and the facility will count these days in addition to reservation days in reporting the total census.

B. Non-Medical Leaves of Absence

Reimbursement will be paid to an ICF/MR facility for a non-medical leave of absence for therapeutic home visits and for trial visits to other facilities. Such visits are encouraged, and the policies of the ICF/MR should facilitate rather than inhibit such absences. Non-medical absences shall be initiated as part of the resident's individual plan of care at the request of the resident, his parent(s), or his guardian with the approval of the QMRP. The Medicaid agency will pay to reserve a bed for up to 21 days per calendar year for a resident residing in an ICF/MR when the resident is absent for therapeutic home visits or for trial visits to another community residential facility. If the resident's bed is used during the individual's absence for short-term emergency or respite care - which in no way would jeopardize or delay the resident's return to the ICF/MR - no additional payment is allowed for such short-term use of the bed for emergency or respite care. The facility will count these days in addition to bed reservation days in reporting the total census.

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